

ORS 656.325(2)

OAR 436-060-0105 Suspension Checklist

Chapter 436, Division 060, Claims Administration, effective April 1, 2011

**INSANITARY OR INJURIOUS PRACTICES, REFUSAL OF TREATMENT
OR FAILURE TO PARTICIPATE IN REHABILITATION**

Claimant _____ Claim Number _____

Claim status: ___Deferred ___Accepted ___Denied ___Partial Denial

DEMAND LETTER

1. _____ The demand letter must require the worker to immediately cease actions which imperil or retard recovery OR to immediately begin to change inappropriate behavior and participate in activities needed to help recovery **0105(2)**

Such actions include:

- _____ insanitary or injurious practices
_____ refusing necessary medical or surgical treatment
_____ failing to participate in a physical rehabilitation program

2. _____ Describe the unacceptable action or inaction **0105(2)(a)**
3. _____ Tell why such conduct is inappropriate and explain how it is harmful or is retarding recovery **0105(2)(b)**
4. _____ Give the date by which inappropriate actions must stop or appropriate actions must begin; specifically describe what the worker must do to comply **0105(2)(c)**
5. _____ Include the boldface/prominent warning paragraph **0105(2)(d)**:

"If you continue to do insanitary or injurious acts beyond the date in this letter, or fail to consent to the medical or surgical treatment which is needed to help you recover from your injury, or fail to participate in physical rehabilitation needed to help you recover as much as possible from your injury, then we will request the suspension of your workers' compensation benefits. In addition, you may also have any permanent disability award reduced in accordance with ORS 656.325 and OAR 436-060."

6. _____ If represented, simultaneously send a copy to the worker's attorney **0105(2)**
7. _____ Simultaneously send a copy to the worker's attending physician **0105(2)**

SUSPENSION REQUEST

1. _____ Copy of request, including all attachments, sent by registered, certified or personal service to worker *0105(5)*
2. _____ If represented, copy of request, including all attachments, simultaneously sent by registered, certified or personal service to worker's attorney *0105(5)*
3. _____ State request is being made under ORS 656.325 and OAR 436-060-0105 *(5)(a)*
4. _____ Describe the worker's actions that prompted the request and state whether the actions continue *0105(5)(b)*
5. _____ State any reasons the worker gave to explain their actions OR state the worker has not provided any reason *0105(5)(c)*
6. _____ State how, when, and with whom the worker's failure to comply was verified *0105(5)(d)*
7. _____ Attach a copy of the original demand letter *0105(5)(e)*
8. _____ Any other relevant information, including (but not limited to), chart notes, surgery or physical therapy recommendations/prescriptions, and all physician or authorized nurse practitioner recommendations *0105(5)(f)*
9. _____ Include the boldface/prominent notice to the worker *0105(5)(g)*

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the mailing date of this request. If the division authorizes suspension of your compensation and you do not correct your unacceptable actions or show us a good reason why they should be considered acceptable, we will close your claim."